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Draft country programme document**

Zimbabwe

Summary

The draft country programme document for Zimbabwe is presented to the Executive Board for discussion and comments. The Board is requested to approve the aggregate indicative budget of $11,115,000 from regular resources, subject to the availability of funds, and $80,000,000 in other resources, subject to the availability of specific-purpose contributions, for the period 2007 to 2011.

* E/ICEF/2006/10.

** In accordance with Executive Board decision 2002/4 (E/ICEF/2002/8/Rev.1), the present document will be revised and posted on the UNICEF website in October 2006, together with the summary results matrix. It will then be approved by the Executive Board at its first regular session of 2007.

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Basic data[†] *(2004 unless otherwise stated)*	
Child population (millions, under 18 years)	6.3
U5MR (per 1,000 live births)	129
Underweight (%, moderate and severe, 2003)	17
Maternal mortality ratio (per 100,000 live births, 2002)	700
Primary school enrolment (% net, male/female, 2003/2004)	79/80
Primary schoolchildren reaching grade 5 (%, 2002/2003)	70
Use of improved drinking water sources (%, 2002)	83
Adult HIV prevalence rate (%, end 2003)	24.6
Child work (%, children 5-14 years old)	26
GNI per capita (US$)	[a]
One-year-olds immunized against DPT3 (%)	85
One-year-olds immunized against measles (%)	80

[†] More comprehensive country data on children and women are available at www.unicef.org.

[a] Range $825 or less.

The situation of children and women

1. Since the late 1990s, the Zimbabwean economy has been underperforming. Negative economic growth rates resulted in a decline of 30 per cent in the gross domestic product between 2000 and 2006. Contributing factors include recurrent droughts, inflation, foreign currency shortages, low investor confidence, policy constraints, limited donor funding and HIV and AIDS. With inflation at 782 per cent as of February 2006 and declining real value of public social investments, the coping capacities of the 63 per cent of the population under the poverty line are severely strained (Poverty Assessment Study Survey, 2003). Thus, Zimbabwe is unlikely to meet most of the Millennium Development Goals. For example, life expectancy at birth for females decreased from 62 to 46 years between 1992 and 2002 (Central Statistical Office, Census 2002). Between 1994 and 1999, infant and under-five mortality rates rose from 52.8 to 65 per 1,000 live births, and from 77.1 to 102.1 per 1,000 live births, respectively. The maternal mortality ratio increased from 283 in 1984 to 695 per 100,000 live births in the period 1995-1999 (Demographic and Health Survey [DHS], 1999). Though recently published information is not available, these indicators have likely worsened.

2. In the last six years the nutritional status of children has stagnated, with stunting remaining at about 27 per cent. Levels of underweight increased from 14 per cent of children in 1999 (DHS, 1999) to 17 per cent in 2003 (National Nutrition Survey, 2003). Malnutrition levels improved slightly in 2004 but deteriorated in 2005. In December 2005 the Zimbabwe Food and Nutrition Site Surveillance System found 3.4 per cent wasting among its 25 sites, with the highest site reaching 7.3 per cent. Underweight averaged 17 per cent, with the highest site reaching 26 per cent. Low birthweight and vitamin A and iron deficiency anaemia remain significant public health concerns, and the elimination of iodine deficiency through universal salt iodization needs continuous monitoring.

3. The immediate causes of increased morbidity and mortality are preventable diseases and malnutrition; underlying causes are HIV/AIDS, food insecurity and deteriorating social services, which adversely impact child-caring capacity and economic productivity. Formerly a net exporter of food, Zimbabwe has received food aid since 2002 because of a combination of consecutive years of drought, the HIV and AIDS epidemic, economic decline and an underperforming agriculture sector. The number of food-insecure people averaged 2.9 million for the 2005-2006 season, of whom 60 to 70 per cent were children and women (Vulnerability Assessment Committee, 2005).

4. The health and education systems, eroded by deteriorating infrastructure, decreased public expenditures and high attrition of human resources, are now characterized by shortages of essential supplies, reduced accessibility by the poor, low motivation of staff and weakened planning and management capacities. The health system has seen the highest erosion of human resources from "brain drain" and AIDS and has a vacancy rate of 50 per cent and 32 per cent for doctors and nurses, respectively. With AIDS patients occupying about 70 per cent of hospital beds, the strain on health services is enormous, making it difficult for the Government to maintain critical services. Coverage with three doses of combined diphtheria/pertussis/tetanus vaccine (DPT3) dropped from 80 per cent in 1999 to 58 per cent in 2003, but rebounded to 85 per cent in 2005 thanks to efforts by the Ministry of Health and Child Welfare with support from UNICEF, the World Health Organization (WHO) and donors. Recurrent cholera epidemics in some districts imply deterioration in hygiene and in the coverage and quality of water and sanitation. About a third of rural water supply facilities are non-functional due to poor maintenance.

5. The decline in HIV adult sero-prevalence from 24.6 per cent in 2003 to 20.1 per cent in 2005 is attributed to a combination of lower rates of new infections and mortality. Nevertheless, an estimated 1.61 million adults (1 in 5) lived with HIV/AIDS in 2005, with 160,000 new infections occurring per year and 3,200 AIDS-related deaths per week. Females comprise 56 per cent of people 15-49 years old living with HIV/AIDS. Unequal gender relations fuel the disease, especially through intergenerational transmission. Over 40 per cent of young women aged 12-19 years have sex with men 5 to 10 years older, and 12 per cent report that their last encounter was forced (Orphans and vulnerable children [OVC] survey, 2004-2005). To halt the epidemic, factors such as the lower social and economic status of women, negative sociocultural practices and gender norms, lack of open discussion on sex, sexually transmitted infections, and HIV and AIDS need to be addressed boldly. Access to treatment and care is inadequate. Of the 364, 000 people requiring antiretroviral therapy (ART), only 23, 000 (6 per cent) received it in 2005, with children aged 0-14 years constituting 7 per cent of them. In 2004, only 7 per cent of all HIV positive pregnant women received antiretroviral (ARV) prophylaxis (Ministry of Health and Social Welfare, 2005).

6. Based on recent surveys, UNICEF estimates that 25 per cent of all children, nearly 1.6 million, were orphans in 2005, and 200,000 children lost one or both parents. Furthermore, the 2002 Census found that 50,000 households were headed by a child under 18. Orphaned children are less likely to access health care, attend school and access basic materials (clothes, blanket, shoes) and are more likely to have psychological problems and to be subjected to forced sex in adolescence, and

these factors result in a higher likelihood of contracting HIV (OVC survey, 2004-2005).

7. Although primary school enrolment rates were above 90 per cent in 2004, and showed gender parity (Ministry of Education, Sports and Culture, 2004), attendance and completion rates have been dropping. In 1999, 84 per cent of rural children aged 6-12 years attended school; in 2004 only 77 per cent did (DHS, 1999; OVC survey, 2004-2005). Completion rates have steadily declined since the late 1990s, to 68 per cent in 2004. Under-spending and the brain drain have negatively impacted a number of quality indicators: in 2004, for example, grade 7 pass rates were at an all-time low of 40 per cent and the textbook-pupils ratio was low, ranging between 1:6 and 1:10 in all subjects (Ministry of Education, Sports and Culture, 2004.

Key results and lessons learned from previous cooperation, 2005-2006

Key results achieved

8. The effective humanitarian responses of UNICEF and its partners, including during Operation *Murambatsvina*, led to increased donor funds, especially for the expanded programme on immunization (EPI), malaria, nutrition, OVC and water and sanitation. These resources funded important results in health, including revamping the cold chain systems and increasing coverage in immunization. Malaria interventions were scaled up: coverage of insecticide-treated nets (ITNs) increased from below 20 per cent to over 50 per cent in high-endemic districts. Vitamin A supplementation reached 82 per cent coverage, and 1.3 million children under five were immunized during national child health days. Innovative procurement arrangements assured uninterrupted availability of ARV and tuberculosis drugs. The programme's water and sanitation humanitarian response reached 220,000 people.

9. The country programme contributed to improved understanding of the situation of children and women through the generation of new knowledge. This included support to the 2004-2005 OVC survey; the national inventory and atlases on water and sanitation facilities and interventions; the mapping of nutrition and OVC programmes; the incorporation of HIV and OVC issues in the 2005 Rural Vulnerability Assessment; and the strengthening and expansion of the Zimbabwe Food and Nutrition Sentinel Site Surveillance System. The programme also supported statistical analysis of education, nutrition and OVC data from various sources. *DevInfo* was used to develop the Zimbabwe Statistics Database (*ZIMDAT*) for monitoring Millennium Development Goals.

10. UNICEF supported the development of national and sectoral policies, including the new National HIV/AIDS Strategic Framework 2006-2011, the National Plan of Action for Orphans and Vulnerable Children (NPA for OVC), the Behaviour Change Strategy and National Treatment Strategic Plan. Furthermore, a national Basic Education Policy, and Gender-based Strategy were developed and a review of social protection programmes was conducted in preparation for the National Poverty Reduction Strategy.

11. The programme supported the Government, non-governmental organizations (NGOs) and community-based organizations (CBOs) to scale up community-level assistance to OVC. The Vice-President launched Zimbabwe's NPA for OVC in late

2005. UNICEF provided technical support to the newly established National Secretariat of the NPA for OVC for costing of the NPA and development of a national monitoring and evaluation system coordinated by the National AIDS Council (NAC). A multi-year and multi-donor programme of support was established to enable the efficient and cost-effective channelling of financial resources to children, families and communities in need.

Lessons learned

12. Collaboration with local authorities, Government institutions, donors and other development partners enabled the programme to reach vulnerable people during the humanitarian response. Good programme planning and technical leadership, taking into account the critical role of development partners and focusing on the respect for and promotion, protection and fulfilment of rights, created an enabling environment for sustained policy dialogue and action in response to evolving situations.

13. A well-facilitated process of assessment, analysis and action (Triple A) involving both duty bearers and children was followed in the development of the NPA for OVC, and the subsequent multisectoral and joint programme of support for OVC was critical for scaling up programmes. New knowledge generated from the Triple A processes was swiftly used to plan interventions and to mobilize human, financial and organizational resources. A transparent monitoring and evaluation system and broadened partnerships widened participation, which facilitated reaching children cost-effectively.

The country programme, 2007-2011

Summary budget table

	(In thousands of United States dollars)		
Programme	*Regular resources*	*Other resources**	*Total*
Basic education and gender equality	2 000	9 000	11 000
Young child survival and development	2 400	13 000	15 400
Water, sanitation and hygiene	1 000	7 000	8 000
HIV/AIDS and young people's development	2 000	8 000	10 000
Child protection	2 000	40 000	42 000
Strategic planning, social policy and communication	1 000	3 000	4 000
Cross-sectoral costs	715	0	715
Total	**11 115**	**80 000**	**91 115**

* Additional funds may be mobilized for humanitarian responses as required.

Preparation process

14. The 2005 Millennium Development Goals progress report highlighted key national priorities and was the foundation for the United Nations Development Assistant Framework (UNDAF). The UNDAF, developed under the guidance of a

task force co-chaired by the United Nations Resident Coordinator and the Office of the President and Cabinet, involved six thematic groups composed of the Government, United Nations agencies and civil society.

15. An internal strategy meeting in late 2005 reaffirmed the need to prioritize activities, create synergies and build partnerships. The identification of priority areas for intervention was further informed by discussions and findings of mid-year and annual reviews and Joint Programme Reviews, including the updating of the Situation Analysis on Children and Women and the findings of the 2004-2005 OVC Survey and Vulnerability Analysis, in which young people participated. This country programme document was developed in consultation with the Government, United Nations agencies, civil society and donors, and the process included a desktop environmental assessment screening.

Goals, key results and strategies

16. The overall goal of the country programme, in line with the UNDAF, is to promote every Zimbabwean child's right to equitable access to good quality services, including those in health; water, sanitation and hygiene; basic education; and protection. The country programme places OVC and HIV and AIDS at its centre by focusing on vulnerability reduction, gender equality, prevention of HIV, and the survival, protection, care, treatment and support, for those living with HIV/AIDS.

17. In **education**, the programme will contribute to these results: (a) net primary and secondary attendance ratios and completion rates increased by 10 per cent; and (b) life and survival skills incorporated in primary education.

18. In **child survival**, the programme will contribute to these results: (a) immunization coverage with routine antigens increased to 90 per cent; routine vitamin A supplementation coverage increased to 80 per cent; polio eradication maintained; and neonatal and maternal tetanus eliminated; (b) coverage of ITNs for children and pregnant women increased to 80 per cent; (c) prevalence of underweight in under-five children reduced to 13 per cent; (d) deficiencies of vitamin A and iron controlled and the elimination of iodine deficiency disorders; and (e) at least 50 per cent of newborns born at home receiving essential care in convergence districts.

19. In **water, sanitation and hygiene (WASH)**, the programme will contribute to these results: access to an improved water sources increased by 20 per cent and access to basic sanitation increased by 10 per cent in convergence districts.

20. In **child protection**, the programme will contribute to these results: (a) an increased proportion of children protected from violence, exploitation, and abuse; (b) at least 25 per cent of needy OVC reached with free basic support; and (c) registered births among children 0-4 years old increased by at least 25 per cent.

21. In **HIV and AIDS**, the programme will contribute to these results: (a) reduction in HIV prevalence among young people (15-24 years) to below 10 per cent; and (b) coverage of home-based care and counselling increased to 25 per cent.

22. In **strategic planning, social policy and communication**, the programme will contribute to these results: (a) strengthened national information and knowledge on the situation of children and women; (b) quality Millennium Development Goals monitoring; (c) the development and implementation of the National Poverty

Reduction Strategy that addresses key challenges for children and women and gender equality; and (d) advocacy for the realization of child rights.

23. The programme will rely on several strategies: (a) development of the capacity of duty bearers at all levels to respect, promote, protect and fulfil children's rights and the development of the capacity of rights holders, especially children, young people and women, to increase their participation and claim their rights; (b) the use of vulnerability analysis to identify districts for convergence of resources; (c) evidence-based advocacy for the development and implementation of child-centred national and sectoral policies, strategies and legal and institutional reforms that ensure the realization and monitoring of child rights; (d) support to nationwide service delivery of immunization and education; and (e) the mainstreaming of emergency preparedness and response.

Relationship to national priorities and the UNDAF

24. The three national priorities of fighting HIV and AIDS, promoting gender equality and women's empowerment, and reducing poverty are articulated in the Millennium Development Goals Reports (2004 and 2005) and are incorporated into the UNDAF outcome areas. The country programme is designed to contribute to five of the six UNDAF outcomes: (a) reduced spread of HIV infection, improved quality of life of those infected and the mitigated impact of HIV and AIDS; (b) improved access to quality and equitable basic social services; (c) gender mainstreamed and institutionalized in all sectors of development; (d) enhanced national capacity and ownership of development processes towards the attainment of the Millennium Development Goals by 2015; and (e) strengthened mechanisms for promoting the rule of law, dialogue, participation in the decision-making process and promotion of human rights.

Relationship to international priorities

25. Both the UNDAF and the country programme aim to accelerate progress on the Millennium Development Goals and *A World Fit for Children* Plan of Action, emphasizing the care and support of OVC and fighting HIV/AIDS. The programme is also guided by the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the African Charter on the Rights and Welfare of the Child. The programme addresses all five focus areas of the UNICEF medium-term strategic plan 2006-2009 and the UNICEF Regional Leadership Agenda.

Programme components

26. **The basic education and gender equality** programme's key results will be achieved through a focus on the education of OVC, especially girls. Improving the quality and relevance of primary and secondary education, strengthening national systems for Educational Management Information, and the Monitoring of Learning Outcomes will contribute to increased enrolment and completion. The review and updating of core curricula will be complemented by improving access to learning materials and improving teacher effectiveness, including through gender-sensitive teaching and psychosocial counselling. The programme will support school, community and institution-based initiatives that develop capacities for early childhood education and care.

27. The incorporation of life and survival skills into primary and secondary education will be achieved through the implementation of the new strategy for HIV and AIDS in Education and Life Skills. To preserve human resources in education, teachers will be mobilized to access appropriate HIV/AIDS prevention and care services, including ARVs.

28. Linkages will be forged between girls' education; child protection; water, sanitation and hygiene; HIV prevention; and young people's participation and school feeding. The main focal partners will be the Ministry of Education, Sports and Culture, the Ministry of Technical and Higher Education, and the NAC, supported by a network of NGOs.

29. Gender will be mainstreamed through the provision of gender-disaggregated data, the promotion of early, positive gender-socialization, the assurance of the safety and security of girls attending school, the prevention of and response to gender-based violence and sexual and economic exploitation. Advocacy for free OVC education and support from the private sector and international community will complement parental, community and Governmental efforts to address the direct and opportunity costs of schooling. The participation of young people in HIV prevention and girls' education will be mainstreamed through school clubs.

30. The **young child survival and development** programme's key results will be achieved through scaling up high-impact interventions against preventable childhood illnesses, malnutrition and maternal health problems. Within the framework of the Integrated Management of Neonatal and Childhood Illness (IMNCI), Roll Back Malaria and Child Survival Partnership initiatives, the programme will support immunization coverage of routine antigens, Vitamin A supplementation, neonatal interventions and the prevention and control of malaria and other childhood diseases. Inputs will include the procurement and distribution of vaccines, supplies, fuel, bottled gas, transport for outreach and essential drugs to support home-based treatment of childhood illnesses and the training of facility and community health workers.

31. To contribute to the reduction of maternal deaths and improve maternal health, the programme will complement United Nations Population Fund (UNFPA) and WHO in providing emergency obstetric care, focusing on community-based schemes for case referral, and the prevention and treatment of malaria and malnutrition during pregnancy. Neonatal care initiatives at facility and community levels will be supported.

32. The programme will contribute to the Universal Access Initiative by mobilizing efforts for increased uptake and coverage of voluntary and confidential counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) of HIV and paediatric AIDS treatment and care. The programme will work with key stakeholders, including civil society organizations (CSOs) in several areas: advocacy for more equitable access to AIDS treatment, especially ART for children and women; procurement of supplies and essential drugs, including ARVs; the training of health workers; and technical backstopping for effective monitoring and accessing of global funds.

33. Support to improved nutrition will emphasize OVC, community capacity development and the integration of nutrition within the overall strategy for HIV and AIDS prevention, care and support, and Community-Based Nutrition. Integration of

community IMNCI, PMTCT, VCT and ARV treatment will include infant and young child feeding. The programme will support the development of a national nutrition policy; a national nutrition surveillance system; elimination of deficiencies of iodine, vitamin A and iron; the therapeutic feeding of severely malnourished children; and in partnership with the World Food Programme (WFP), the continuation of technical support to feeding programmes.

34. The programme's focal points are the Ministry of Health and Child Welfare, NAC, the Food and Nutrition Council and Rural Development Councils.

35. The key results in the **water, sanitation and hygiene (WASH) programme** will be achieved within the framework of the national water and sanitation policy through strengthened Government coordination, capacity development for community and school participatory health, hygiene and sanitation education, as well as management of water and waste systems in rural and peri-urban areas. Efforts will focus on households and communities most affected by HIV/AIDS. To improve the school environment for girls, the programme will support the rehabilitation of school water and sanitation facilities. The capacity of teachers to inform students about WASH, including the critical role of hand washing with soap, will be developed. Partnerships with the public sector, donors and NGOs will be broadened so that community and district capacities can be developed for preparedness and response to outbreaks of water- and hygiene-related diseases such as cholera, diarrhoea and malaria. The programme's focal points are the Ministry of Local Government and Urban Development, the Ministry of Health and Child Welfare, the Ministry of Water and Infrastructural Development and Rural Development Councils.

36. The **child protection** programme's key results will be achieved through addressing issues such as harmful traditional and religious practices (especially those that elevate the HIV risk for girls, including child marriages), the worst forms of child labour, trafficking and deportation, justice for children in contact with the law (children as victims/offenders), violence and abuse, unaccompanied and separated children, and children with disabilities. The programme will support the Ministry of Public Service, Labour and Social Welfare and its National Secretariat and the NAC in advocacy and mobilizing and convening partners for a large-scale response to the challenges facing OVC. The programme will coordinate the implementation of a multi-donor programme of support for the NPA for OVC, ensuring that substantial resources are mobilized and channelled to communities, families and children through intermediary organizations. District-level Child Protection Committees and other district coordination mechanisms will be established or strengthened.

37. To ensure universal early birth registration, measures such as the establishment of sub-offices and mobile teams to reach children in remote areas will be supported. The programme will also work to reunify unaccompanied and separated children (both those on the streets and in institutions); to prevent abuse, exploitation and trafficking of children, with cross-border collaboration; to provide support services for victims and strengthen the victim-friendly court system; and to implement recommendations from the United Nations Study on Violence against Children.

38. The **HIV/AIDS and young people's development** programme will achieve its results by supporting large-scale, effective interventions within the context of United Nations joint programming, including the following; (a) implementation of

the National Behaviour Change Strategy to ensure a focus on young people; (b) improved quality and coverage of community-based care and counselling services; (c) the leveraging of resources, such as those of the Global Fund; (d) the dissemination of new knowledge and documentation of best practices and lessons learned; (e) improved national tracking systems and critical epidemiological analysis; and (f) strengthening the capacities of key partners for effective coordination and implementation of HIV/AIDS prevention and care interventions. The main counterparts will be the NAC and the Ministry of Health and Child Welfare.

39. In collaboration with UNFPA, the United Nations Development Fund for Women and the United Nations Development Programme (UNDP), the programme will address sociocultural and gender-related norms and practices that fuel the spread of HIV, particularly among girls and young women, including gender-based violence and intergenerational sex. The programme will promote and support home-based care and community counselling; participation of young people in prevention activities; peer counselling and life skills initiatives; the development and dissemination of appropriate youth-friendly information, education and communication and training materials; and support to interventions focused on improving communication and connectedness between young people and their parents and other community members.

40. **The strategic planning, social policy and communication** programme will work with the Government of Zimbabwe, the World Bank, UNDP, UNFPA, donors and CSOs in the development and implementation of a National Poverty Reduction Strategy and Poverty Alleviation Action Plan, focusing on children and women and with a view to improving macro-economic fundamentals, including the reduction of inflation, capacity development for governance systems and the stimulation of private sector and better pro-poor and child-friendly investments and expenditure. Gender will be mainstreamed through the provision of gender-disaggregated data. The programme will coordinate linkages with the UNDAF and support capacity development in monitoring and evaluation to inform evidence- based policy development. In addition, the country programme will promote and enhance a national protection system for child rights that reflects international human rights norms, informed by the UNICEF/Government of Zimbabwe 2004 legal review of children and women's rights. Child rights monitoring, through support to the State Party reporting process and capacity development for national institutions, will be key to ensuring quality and timely reporting on the Convention on the Rights of the Child (the last State Party report was submitted in 1996) and the Convention on the Elimination of All Forms of Discrimination against Women. The programme will also promote the participation of children and young people in national processes such as the Millennium Development Goals campaign and child-friendly budget initiative.

41. Strategic, evidence-based advocacy and communication involving media, public mobilization and community dialogue will be implemented for leveraging resources and social and behavioural change. Advocacy for the realization of child rights, focusing on OVC and HIV/AIDS within the larger United Nations global campaign for children and AIDS, will be coordinated with Government line Ministries, other United Nations agencies, donors and National Committees for UNICEF to mobilize the increased commitment of policy makers, politicians,

donors, the private sector, civil society groups and other partners to fulfilling obligations to children.

42. The programme integrates preparedness and response to protect children in accordance with UNICEF Core Commitments for Children in Emergencies. Governmental capacity will be developed for improved coordination of humanitarian actors through cluster working groups and the training of stakeholders on the code of conduct to prevent violence and abuse in humanitarian contexts. The programme will also contribute to the provision of emergency relief for the most vulnerable and provide support to the Government, in coordination with WHO and the Food and Agriculture Organization of the United Nations (FAO), to help prepare for the potential threat of avian flu.

Cross-sectoral costs

43. The programme support component will cover recurrent costs, including salaries, utility costs and security to ensure compliance with the United Nations Minimum Operating Security Standards.

Major partnerships

44. The country programme will be a key component of the broad United Nations partnership described in the UNDAF. Building on lessons learned from the last country programme, UNICEF will continue to be an active member of Government and United Nations-led coordination bodies — including the Working Party of Officials for the NPA for OVC, the Child Protection Working Group, the EPI and Malaria Inter-Agency Coordination Committees, the National Reproductive Health Task Force and Steering Committee, the Expanded Theme Group on HIV/AIDS, the United Nations technical working group on HIV/AIDS, the national PMTCT Partnership Forum, the National Care and Treatment Partnership Forum and the national HIV/AIDS Monitoring and Evaluation Task Force.

45. New strategic alliances will include the United Nations Joint Expanded Support Programme on HIV/AIDS (with the Joint United Nations Programme on HIV/AIDS, UNFPA, WHO and UNDP) and a joint programme with UNFPA and UNDP aimed at strengthening national statistical and Millennium Development Goals monitoring capacity. In education, joint programming with the United Nations Educational, Scientific and Cultural Organization, WFP, FAO, the SNV Netherlands Development Organisation and the European Union/Education Transition Recovery Programme will address girls' education, HIVAIDS and livelihoods at district level. Partnerships with children, donors and implementers at the district and community levels (including NGOs and community and faith-based organizations) will be deepened and broadened.

Monitoring, evaluation and programme management

46. The UNDAF results matrix and monitoring and evaluation plan will provide the overall framework for monitoring and evaluating the achievement of UNDAF outcomes, while a related five-year and annually updated Integrated Monitoring and Evaluation Plan will guide detailed monitoring and evaluation of the country programme. In collaboration with the Central Statistical Office and a United Nations working group on data for development, UNICEF will support the use of *ZIMDAT*, to systematically monitor progress on the Millennium Development Goals. The

2004-2005 OVC survey and the 2006 DHS will provide baseline data for most of the basic indicators.

47. To arrive at a common analysis and provide the basis for further development of programme interventions and advocacy for children, the programme will support a systematic national research agenda on children and women, including through developing the capacity of district authorities to gather disaggregated data through the Village Register. Capacity development among UNICEF staff and partners on performance standards and field visits will further improve monitoring, evaluation and documentation of interventions and will generate lessons for reinforcing and widening the Triple A process.

48. The Programme Development and Monitoring Committee, co-chaired by the Ministry of Finance and the UNICEF Representative, will guide and oversee the programme. Annual reviews will be carried out jointly with the Government and other United Nations agencies within the context of the UNDAF. Internal management will continue to take place through monthly review meetings of the country management team and the programme management team.